

Montana WC Nonfacility Fee Schedule Instruction Set For 2008

Version 1, September 2007

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Montana WC Nonfacility Fee Schedule Instruction Set

Section One: Introduction

Research and Legislative Background

The Montana workers' compensation medical fee schedule has been in place since 1973. For much of its history, it has been based on the Relative Values for Physicians' relative value unit (RVU) system. In recent years, many state workers' compensation medical fee schedules have transitioned to the Resource Based Relative Value Scale (RBRVS) developed by the Centers for Medicare and Medicaid Services (CMS) based on national medical market data. In Montana, our major medical insurance payers, Medicaid, Medicare, and Blue Cross/Blue Shield of Montana, all use the RBRVS-based reimbursement system.

Over the past five years, staff of the Medical Regulations Unit of the Employment Relations Division (ERD) in the Montana Department of Labor and Industry have been researching and soliciting input from stakeholders on the feasibility and benefit of converting the Montana workers' compensation medical fee schedule to an RBRVS-based system. This would provide some consistency with the major medical insurance payers for efficiency and convenience of both providers and payers. In January 2007, ERD sponsored a two-day Education Conference on Montana workers' compensation issues that focused extensively on medical concerns. National experts on workers' compensation medical issues presented their findings to the conference.

As a result, the 2007 Legislature passed legislation that directs the Department to establish an RBRVS-based fee schedule for nonfacility medical services provided to injured workers. The legislation was endorsed by the Labor-Management Advisory Council on Workers' Compensation that represents both employers and employees and is chaired by the Lieutenant Governor. The Council will continue to provide input and guidance in the implementation of the new Montana workers' compensation medical fee schedule.

The new billing and reimbursement process is described on the following pages of the Montana WC Nonfacility Fee Instruction Set. The Montana Department of Labor and Industry has attempted to implement the new statutes adopted by the 2007 Legislature as effectively as possible. We welcome and encourage any suggestions for improvement to the Instruction Set and the Fee Schedule that the readers and users may offer.

Conversion Factors

There are two different conversion factors (CF) for Montana WC fee schedules in 2008. Montana mirrors the two-tier CF system of the national RBRVS, one for anesthesiology, and one for all other services, procedures, and supplies. Details on calculating the anesthesiology fee can be found in the Anesthesia section below.

The standard conversion for Montana WC fee schedules in 2008 is \$63.45. The anesthesiology conversion factor for the Montana WC fee schedule in 2008 is \$57.20.

The new schedule is effective January 1, 2008. The department will post these CF on our web page and update it annually.

Related RBRVS Terminology

American Medical Association (AMA) --- The association that develops, updates and publishes the Physicians Current Procedural Terminology (CPT) coding system for medical services and procedures (HCPCS Level I codes). CPT codes provide an effective, consistent language for nationwide communication among physicians, insurance payers, and patients.

Category II and III Codes---Temporary sets of codes used for tracking emerging technologies, services, and procedures. Not reimbursable without pre-authorization, these codes are used to document use levels for future setting of RVUs if a given code is converted into a permanent CPT or HCPCS. These codes are typically five alphanumeric digits, with a letter in the last field, for example 1234T.

Centers for Medicare and Medicaid Services (CMS) ---the government agency responsible for overseeing and administering the Medicare and Medicaid programs. (Formerly the Health Care Financing Administration or HCFA). CMS annually

publishes the relative value units (RVUs) known as RBRVS for the reimbursement of medical services. The RBRVS is the basis for reimbursement in Montana for WC medical services and procedures, therefore, changes that CMS makes to the RBRVS may well have an impact on Montana's new WC reimbursement system.

CF — See Conversion Factor

Conversion Factor (CF) — The conversion factor represents the dollar value of each relative value unit. When this dollar amount is multiplied by the total relative value units (RVU) (facility or nonfacility) assigned to a specific service or procedure, it will yield the allowed fee for that specific service or procedure.

CPR — See Customary, Prevailing, and Reasonable Charge

Customary, Prevailing, and Reasonable Charge (CPR) — the basis for Medicare's reimbursement rates prior to the RBRVS. CPR reimbursement rates were based on historical medical provider charges rather than relative values, which allowed for wide variation in Medicare payments among medical providers and specialties. See Usual and Customary Charge, which is the Montana variation on this terminology.

Diagnosis Related Group (DRG) — this system classifies facility admissions based on their illness (diagnosis) and the treatment provided. It is assumed that patients with similar illnesses undergoing similar procedures will require similar resources. This payment methodology, therefore, reimburses facilities on a flat-rate basis based on the patient's diagnosis and treatment.

DRG — See Diagnosis Related Group

Evaluation and Management Services (E/M) — Medical services provided to patients that involve visits, examinations and consultations, both in facilities (hospitals, ambulatory surgery centers (ASC), skilled nursing facilities (SNF), or other licensed medical facility settings) and at nonfacility (physicians office, patient's home, or other nonfacility) locations.

E/M Services — See Evaluation and Management Services

Facility Reimbursement — the medical provider's allowed fee for each service when that service or procedure is provided in a hospital, ambulatory surgery center (ASC), skilled nursing facility (SNF), or other licensed medical facility setting. Critical access hospitals (CAHs), however, are a separate medical classification and are reimbursed by the Montana WC fee system at 100 percent of charges. Actual reimbursement for the facility, in contrast to reimbursements made to individual medical providers performing these services or procedures while at a facility, will be the subject of a separate **Montana Facility Fee Schedule (MFFS)** still to be developed.

Gap — Services not covered by Medicare and/or not assigned a relative value in the RBRVS system. See the HCPCS section at the end of this instruction set for more details about determining allowed fees for gap services.

Gap Code — Any Level I (CPT) or Level II (HCPCS) code that is not given an RVU by CMS. See the HCPCS section at the end of this instruction set for more details about determining allowed fees for gap services.

HCPCS — HCPCS is an acronym for Healthcare Common Procedure Coding System. It is a two-tier medical coding system composed of HCPCS Level I (CPT) codes and HCPCS Level II national codes.

- **Level I Codes** — the first level of the HCPCS system is the American Medical Association's Current Procedural Terminology (CPT) codes. This code set, known universally as CPT, reports a broad spectrum of medical procedures and services.
- **Level II Codes** — this is the second level of the HCPCS system and is developed by CMS to report services and supplies not found in the CPT system. These Level II national codes are commonly referred to collectively as HCPCS.

Montana Nonfacility Fee Schedule (MNFS) — the allowed fees paid to individual medical providers for Montana workers' compensation medical procedures and services provided in nonfacility settings, such as a medical provider's office, and facility settings, such as a hospital. These fees are based on a resource-based relative value scale (RBRVS) by which a relative value unit (RVU) is assigned to a specific service or procedure. The RVU is then multiplied by the Montana WC conversion factors to determine the Montana reimbursement amount to individual medical providers for nonfacility medical procedures and services.

MNFS — See Montana Nonfacility Fee Schedule

Nonfacility Reimbursement — the allowed fee paid for each service when that service is provided in nonfacility settings,

such as the physician's office, patient's home, or other nonfacility setting.

RBRVS — See Resource Based Relative Value Scale

Relative Value (RV) — RBRVS ranks each service or procedure based on the relative costs required to provide them. A relative value reflects the cost of providing a specific medical provider's service as compared to the cost of providing all other services and procedures.

Relative Value Unit (RVU) — Relative values are expressed in numeric units that represent the unit of measure of the cost of providing a medical service. Those services that have greater costs have greater relative value units than those services with lower costs.

Resource Based Relative Value Scale (RBRVS) — Payment schedule based on the relative values of services provided. The current RBRVS system ranks services according to the relative costs required to provide them. These costs are defined in terms of units, with more complex, more time-consuming services having higher unit values than less complex, less time-consuming services. Furthermore, each service is compared to all other medical services so that each service is given a value that reflects its cost when compared to all other medical services.

Usual and Customary Charge — In contrast to "Customary, Prevailing, and Reasonable Charge," or to "Usual, Customary, and Reasonable Charge," Montana instead employs the terminology "Usual and Customary Charge," which means the regular medical charge that a facility or individual medical provider makes for the service or procedure provided to any non-WC patient.

WC — See Workers' Compensation

Workers' Compensation (WC) — the system established in Montana (and in variations in the other states) for seeing to the medical and income-loss needs of Montana workers injured in the workplace.

Description of Columns in Montana WC Nonfacility Fee Schedule

Code Column

The Code column lists the current five character numeric or alphanumeric codes designated in the Montana Nonfacility Fee Schedule corresponding to the description in Current Procedural Terminology (CPT) developed by the American Medical Association (AMA), the HCPCS Level II description for the alphanumeric codes developed by CMS or Category II and III codes used for data tracking. Montana WC fee schedules rely on CPT and HCPCS codes for recording, reporting and reimbursing WC medical claims.

Modifier Column

The modifier column is used to further describe the services rendered.

Modifier 26 is used to designate the cost of professional services required for the performance of that service or procedure.

Modifier TC is used to designate the personnel, equipment, and facility costs related to providing that particular service or procedure.

Modifier 53 indicates a started but discontinued procedure. See the modifier section later in this Introduction for more information about modifier 53.

Modifiers associated with HCPCS Level II codes include NU (New Equipment), RR (Rental, used when a DME [Durable Medical Equipment] is rented), and UE (Used Durable Medical Equipment).

NonFacility and Facility Reimbursement Columns

The reimbursement amount in these two columns applies, based on the definitions for these terms in the Related RBRVS Terminology section above.

Gap Code Column

A ■ symbol in this column indicates that the relative value was established by Ingenix. More details about Gap codes can be found at the end section (Section Eight: HCPCS, subsection III. Gap Values) below.

Modifier 51 Exempt Column

Codes with the numeric unit 1 (one) in this column are exempt from modifier 51. See the definition of Modifier 51 in the Modifiers section below.

Add-On Code Column

Codes with the numeric unit 1 (one) in this column are considered add-on codes by the AMA.

Utilization (and Treatment) Rules Column

Utilization and treatment rules in this column are based on ARM (Administrative Rules of Montana) 24.29.... and currently are primarily limited to descriptions for Physical Medicine (PM) services and procedures. When medical providers identify services or procedures for the WC patient that exceed the quantity or combinations of services set by Administrative Rule, medical providers can contact the WC insurer representative for pre-authorization to exceed these utilization and treatment guidelines.

In the Physical Medicine (PM) portion of the Fee Schedule, CPT codes 97001 through 99215 inclusive are allowed without prior authorization unless otherwise mentioned. Each RVU value in this PM section is based on a 15 minute unit, and no more than five (5) codes per office visit are allowed without prior authorization. The following abbreviations are used in the PM section: PA (Prior Authorization is required); C (Chiropractic); OT (Occupational Therapy); N/A (not allowed); and PT (Physical Therapy).

CPT codes 99455 and 99456 have been used in the Montana workers' compensation fee schedules applicable before January 1, 2008, and their RVU values were based on values from the Relative Values for Physicians (RVP) system. These codes do not have RVUs in the RBRVS. The department has therefore created the following values for these codes: 99455 is 2.5 RVU; and 99456 is 2.8 RVU.

Under Montana fee schedules in previous years under the RVP system, code 97799 applied only to chiropractors, occupational therapists and physical therapists, and allowed billing for payor conferences. Beginning on January 1, 2008, the new, unique-to-Montana code MT001 is being used to apply the substance of code 97799 to all medical providers, at a RVU reimbursement rate of 0.5, for following services: a) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor; b) a report associated with non-physician conferences required by the payor; or c) completion of a job description or job analysis requested by the payor. This CPT value is for each 15 minute unit.

Modifiers

Listed codes may be modified under certain circumstances. Two reference sources for modifiers are available. One source is the CPT book, which contains the AMA's modifiers for use with CPT codes, while the other source is CMS, which has developed additional modifiers.

CPT modifiers are two-digit numeric codes listed after the procedure code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" after the usual procedure number (e.g., 47600 22). The fee should be the total fee for the procedure. Modifier descriptions should be carefully reviewed because in recent years, significant revisions have been made to modifier descriptions. In addition, some modifiers are specific to certain types of services.

HCPCS Level II modifiers have been developed by CMS and consist of either two alpha characters (e.g., QB) or one alpha and one numeric character (e.g., T1). They are listed after the CPT or HCPCS Level II procedure code (e.g., 28112 T1).

Modifier codes listing additional value show customary increases, when available. When multiple modifiers are needed, use modifier 99.

CPT Modifiers

Listed below are CPT modifiers for medical services. Select HCPCS Level II modifiers are described in the introductions to the various sections. For a complete listing of current HCPCS modifiers, consult a current HCPCS Level II resource.

- 21 Prolonged Evaluation and Management Services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code. Time must be documented.
- 22 Unusual Procedural Services:** When the service(s) provided is greater than that usually provided for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. Documentation must support the use of modifier 22. The allowed fee increases by 25 percent with the use of this modifier.
- 23 Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia (e.g., proctoscopy) or local anesthesia (e.g., skin biopsy or excision of subcutaneous tumor), because of unusual circumstances (e.g., age, noncooperation of patient) must be done under general anesthesia. This circumstance is reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Service by the Same Medical provider During a Postoperative Period:

The medical provider may need to indicate that an evaluation and management service was performed during a postoperative period for reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service. Service should be substantiated by report and establishes a value of 100 percent of listed reimbursement for the service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Medical provider on the Same

Day of Procedure or Other Service: The medical provider may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see the Evaluation and Management Services guidelines below for instructions on determining the level of E/M service). Properly documented, the payment amount is 100 percent of the allowed fee. The E/M service may be prompted by the symptom or condition for which the procedure and/or service provided. As such, different diagnoses are not required for reporting the E/M services on the same date. This circumstance may be reported by appending modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

26 Professional Component: Certain procedures are a combination of a medical provider component and a technical component. When the medical provider professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure.

32 Mandated Services: Services related to mandated consultation and/or related services may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code. The first procedure will pay at 100 percent of the allowed fee and the second procedure will pay at 50 percent of the allowed fee.

51 Multiple Procedures: When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes. See the Surgery section below for further details.

52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the medical provider's discretion. Under these circumstances the services provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

53 Discontinued Procedure: Under certain circumstances the medical provider may elect to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the medical provider for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

54 Surgical Care Only: When one medical provider performs the surgical procedure and another provides the preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only: When one medical provider performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only: When one medical provider performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the

surgery may be identified by adding modifier 57 to the appropriate level of E/M service. Properly documented, the payment amount is 100 percent of the allowed fee.

- 58 Staged or Related Procedure or Service by the Same Medical Provider During the Postoperative Period:** The medical provider may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. These circumstances may be reported by adding modifier 58 to the staged or related procedure. Properly documented, the payment amount is 100 percent of the allowed fee. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.
- 59 Distinct Procedural Service:** Under certain circumstances, the medical provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/ excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same medical provider. When another already established modifier is appropriate, however, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. This modifier neither increases nor decreases the amount of the allowed fee.
- 62 Two Surgeons:** When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added as appropriate. Modifier 62 is used primarily when two surgeons with different skills are required in the management of a specific surgical problem (e.g., a urologist and a general surgeon in the creation of an ileal conduit). The adjusted payment of the procedure will be 125 percent of the regular allowed fee, with the reimbursement to be apportioned in relationship to the responsibility and work done.
- 63 Procedure Performed on infants less than 4 kg:** Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and medical provider work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology or Laboratory, or Medicine sections. Properly documented, the payment amount is 125 percent of the allowed fee.
- 66 Surgical Team:** Under some circumstances, highly complex procedures (requiring the concomitant services of several medical providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating medical provider with the addition of modifier 66 to the basic procedure number used for reporting services.
- 76 Repeat Procedure by Same Medical provider:** The medical provider may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.
- 77 Repeat Procedure by Another Medical provider:** The medical provider may need to indicate that a basic procedure or service performed by another medical provider had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service. Properly documented, the payment amount is 125 percent of the allowed fee.
- 78 Return to the Operating Room for a Related Procedure During the Postoperative Period:** The medical provider may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see 76.) Properly documented, the payment amount is 70 percent of the allowed fee.
- 79 Unrelated Procedure or Service by the Same Medical provider During the Postoperative Period:** The medical provider may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on

the same day, see 76). Properly documented, the payment amount is 100 percent of the allowed fee.

- 80 Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s). Properly documented, the payment amount is 20 percent of the allowed fee.
- 81 Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number. This modifier may also be used to identify assistant surgeon services provided by physicians, and is reimbursed at 15 percent of the allowed fee. The payment is 15 percent of the allowed fee when non-physician surgical assistant services are appropriate. See section Three: Surgery XV for providers qualifying as surgical assistants.
- 82 Assistant Surgeon (when a qualified resident surgeon is not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s). The payment is 20 percent of the allowed fee.
- 90 Reference (Outside) Laboratory:** When laboratory procedures are performed by a party other than the treating or reporting medical provider, the procedure(s) may be identified by adding modifier 90 to the usual procedure number.
- 91 Repeat Clinical Diagnostic Laboratory Test:** In the course of patient treatment it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results due to testing problems with the specimens or equipment or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/ suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.
- 99 Multiple Modifiers:** Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

Section Two: Anesthesia

- I. General:** Values for anesthesia services are listed by CPT code in the Anesthesia section. These values are to be used only when the anesthesia is legally administered by or under the responsible supervision of a licensed medical provider. These values include usual pre- and postoperative visits, the administration of the anesthetic and administration of fluids and/or blood incident to the anesthesia or surgery. Calculated values as derived from the base unit and time increments are discussed under Calculations of Total Anesthesia Values.
- II. Unlisted Service or Procedure:** When an unlisted service or procedure is provided, the value should be substantiated by report (BR).
- III. Materials Supplied By Medical provider:** Identify as 99070 or by specific HCPCS Level II code(s). The codes identify supplies and materials provided by the medical provider (e.g., dressings, casting supplies, drugs, etc.) over and above those usually included with the office visit or other services. For codes (such as 99070) without a listed value in RBRVS, please refer to rule 24.29.1521 of the Administrative Rules of Montana (ARM). Use HCPCS codes for identifying supplies.
- IV. Stand-by Anesthesia:** When an anesthesiologist is requested by the attending medical provider to be present in the operating room to monitor vital signs and manage the patient from an anesthesia standpoint, even though the actual surgery is being done under local anesthesia, calculation will be the same as if general anesthesia had been administered (time + base value). If not properly documented, insurers may not pay for stand-by anesthesia.

Stand-by anesthesia is generally accepted without justifying documentation for the following:

- Deliveries
- Subdural hematomas
- Femoral or brachial arterial embolectomies
- Patients with physical status 4 or 5—the medical provider must document the patient's condition (e.g., severe systemic disease, moribund patient). See below for the section on Physical Status Modifiers.
- Insertion of a cardiac pacemaker
- Cataract extraction and/or lens implant

- Stand-by anesthesia for other than the above generally requires documentation

- V. More Than One Anesthesiologist:** When it is necessary to have a second anesthesiologist, the necessity should be substantiated by report (BR). The second anesthesiologist receives 5.0 base units plus time units (calculation of total anesthesia value). If not properly documented, insurers may not pay for more than one anesthesiologist.
- VI. Modifiers:** All anesthesia services are reported by using the anesthesia five-digit procedure code (00100-01999) plus the addition of a physical status modifier. These modifying units may be added to the basic values and documentation must support the Physical Status modifier used. The use of other modifiers may be appropriate. A comprehensive listing of CPT compatible modifiers is provided in the Introduction (Section I) above.
- VII. Physical status** modifiers are represented by the letter P followed by a single digit defined below:

Modifier	Physical Status	Unit Values
P1	Healthy patient	0
P2	Patient with mild systemic disease	0
P3	Patient with severe systemic disease	1
P4	Patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor	0

Example: 00100 P1

- VIII. Qualifying Circumstances:** Some circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. More than one code may be necessary. The value listed is added to the existing anesthesia base.

CPT	Description	Unit Values
99100	Anesthesia for patient of extreme age, under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency* conditions (specify)	2

An emergency is determined to exist when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.

- IX. Reporting Anesthesia Base Units When Two or More Surgical Procedures are Performed:** Typically, only a single anesthesia base unit is reported when multiple surgical procedures are performed. The base unit for anesthesia, when multiple surgical procedures are performed during a single anesthetic administration, is the basic value for the procedure with the highest unit value. The appropriate base units, modifying units, and time units may be applied to each anesthesia administration. The exception is when an add-on anesthesia code is available for reporting an additional service or procedure. Add-on anesthesia codes are services that may be carried out in addition to the primary procedure. The CPT code for the add-on service and any associated base units may be reported in addition to the primary anesthesia service.
- X. Status Code:** The Introduction provides a complete description for the status code column (abbreviated as S). The Anesthesia section contains the following status codes: J for Anesthesia Services.
- XI. Calculations of Total Anesthesia Values:**
The total anesthesia value is calculated by adding the separately listed basic value and time value. A basic value is listed for most procedures. This includes the value of all anesthesia services except the value of the actual time spent administering the anesthesia or in unusual detention with the patient. When multiple surgical procedures are performed during the same period of anesthesia, only the greater basic anesthesia value of the various surgical procedures should be used as the base. An exception is when an add-on anesthesia code is available for reporting the additional service. When an add-on code applies, the add-on code and any associated base units are reported in addition to the primary anesthesia service.

The time value is computed by allowing 1.0 RVU unit for each 15 minutes of anesthesia time, and should be

calculated on a minute-by-minute basis. Because the conversion factor for anesthesiology for each additional time value of one-15 minute period is \$57.20, the per-minute reimbursement amount is \$3.81.

Anesthesia time begins when the anesthesiologist physically starts to prepare the patient for the induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist is no longer in constant attendance (when the patient may be safely placed under postoperative supervision).

A: The following examples illustrate the calculation of total anesthesia values if you are using the CF in the Essential RBRVS:

1. Procedure Number + Anesthesia Modifier or Anesthesia Code

Basic Value

+ Time Value

= Total Anesthesia Value (sum of basic value and time value)

2. For a needle thyroid biopsy performed in 48 minutes (three whole time units [45 minutes] plus three partial time units [3 minutes]):

00322	Basic Value	3	
	+ Time Value	3	
	= Subtotal	6	(total whole units anesthesia value)

Subtotal Whole Units Conversion	\$343.20	(six units x \$57.20)
+ Partial Time Value	\$11.43	(three minutes x \$3.81)
= Full Reimbursement	\$354.63	

B: The following examples illustrate the calculation of total anesthesia reimbursements if you are using the allowed amounts already calculated in the Montana Nonfacility Fee Schedule (MNFS):

1. Procedure Number + Anesthesia Modifier or Anesthesia Code

Basic Allowed Amount listed in the MNFS

+ Time Value

= Total Anesthesia Reimbursement (sum of basic allowed reimbursement amount and time value)

2. For a needle thyroid biopsy performed in 48 minutes (three whole time units [45 minutes] plus three partial time units [3 minutes]):

00322	Basic Allowed Amount	\$ 171.60	
	+ Time Value	\$ 171.60	(three whole time units [\$57.20 x 3])
	= Subtotal	\$343.20	(total whole units anesthesia value)
	+ Partial Time Value	\$ 11.43	(three minutes x \$3.81, or \$11.43)
	= Full Reimbursement	\$ 354.63	

Note: Modifiers and additional or reduced values should be used when appropriate.

Section Three: Surgery

- I. **General:** If a relative value is not available for a procedure, it is indicated with a "0.00" in the total units column. When no total relative value unit has been established, the value should be substantiated by report (BR). Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service or supply. For example, some surgery codes, such as cystometrograms (51725 TC, 51726 TC), have technical components so the medical provider work component does not apply and this is indicated with "0.00."
- II. **Modifiers:** Modifiers identify circumstances that alter or enhance the description of the service. Some surgery codes have modifiers that affect the assigned unit value and are listed on our Montana WC fee schedule webpage. Other modifiers, however, may be required for correct reporting of the service. Listed modifiers in this Surgery section are as follows:
 - A. **Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical value of providing that service. The following sections, professional and technical, provide additional definitions for each component.
 - B. **Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring medical providers.
 - C. **Technical:** Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service.
 - D. **Started But Discontinued Procedure:** Modifier 53 indicates a started but discontinued procedure. See the modifier section in the Introduction for more information about modifier 53.
- III. **Global Values**
 - A. **Therapeutic Surgical Procedures:** The relative values for therapeutic surgical procedures are considered global and include:
 1. The immediate preoperative care that starts after the decision for surgery has been made. Modifiers must be used when E/M services are provided prior to immediate preoperative care, under certain circumstances. These circumstances include decisions made either: a) the day of surgery for procedures in which the global period is 0 or 10 days, modifier 25; or b) the day before or the day of surgery for procedures in which the global period is 90 days, modifier 57.
 - a. Additional value is warranted for preoperative services under the following circumstances:
 - (1) Evaluation and management services unrelated to the primary procedure, but related to the injury.
 - (2) Services required to stabilize the patient for the primary procedure
 - (3) When procedures not usually part of the basic surgical procedure (e.g., bronchoscopy prior to chest surgery) are provided during the immediate preoperative period, but related to the injury.
 - b. The following is included in the surgical package and additional value is not warranted:

A single E/M encounter subsequent to the decision for surgery immediately prior to or the day of surgery, including history and physical exam.
 2. The surgical procedure, including local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia (when used).
 3. Normal uncomplicated follow-up care for the period indicated "global."

Some circumstances warrant additional value when care is rendered during the follow-up period, including repeat services (76, 77), related procedures (78), unrelated care (79, 24), or staged procedures (58). See also Modifiers listed in the Introduction.
 - B. **Diagnostic Procedures (e.g., endoscopy, injection procedures for radiography, etc.):** Only that care related to the diagnostic procedure itself is included in the global value. The condition for which the diagnostic procedure was performed or other concomitant conditions is not included and may be listed separately.
- IV. **Separate Procedure:** Procedures identified as "separate procedure" are frequently included in the global value of other procedures. Listing of separate codes is not appropriate when a procedure is included in the global value of another (e.g., code 29870 is not appropriate to list in conjunction with 29874 when performed on the same side).

- V. Unusual Service or Procedure:** A service may necessitate use of the skills and time of the medical provider over and above listed services and values. If substantiated by report (BR), additional value may be warranted. Use modifier 22 to indicate greater complexity.
- VI. Unlisted Service or Procedure:** When a service or procedure provided is not adequately identified, use of the unlisted procedure code for the related anatomical area is appropriate. Unlisted codes have "9" for the last digit, with a few exceptions. Service must be substantiated in the documentation.
- VII. By Report (BR):** The value of a procedure should be established for any "by report" circumstance by identifying a similar service and justifying value difference. When a report is indicated, the report should include the following:
- Accurate procedure definition or description
 - Operative report
 - Justification for procedural variance, when appropriate
 - Similar procedure and value comparisons
 - Justification for value difference
- VIII. Reduced Services:** Under some circumstances, value for a procedure may be reduced or eliminated. Use modifier 52 to identify reduced value services.
- IX. Operating Microscope:** When an operating microscope is used to perform a procedure, the use of code 69990 is appropriate. Do not report 69990 in addition to procedures where the use of the operating microscope is an inclusive component. Note: Value is equal to 25% of primary procedure.
- X. Anesthesia By Surgeon:** Regional or general anesthesia provided by a surgeon should be indicated using modifier 47. The surgeon may receive a value for the procedure equal to the base anesthesia value listed in the anesthesia section. It is important to remember that anesthesia and surgery relative value units are based on different scales and conversion factors may vary significantly.
- XI. Preoperative, Surgery, and/or Postoperative Care Provided By Different Medical Providers:** Montana workers' compensation utilizes the following rules for postoperative and surgical care modifiers to determine the preoperative and postoperative percentages on an individual code basis. The percentage by surgery section is: preoperative, using modifier 56 to identify preoperative only care, 10%; surgery, using modifier 54 to identify surgical services only, 70%; and postoperative, using modifier 55 to identify postoperative care only, 20%. For inpatient services, postoperative care percentages represent the percentage applied after hospital discharge:
- A. Surgical Care Only:** When a medical provider provides only the surgical care and another medical provider provides preoperative and postoperative care, this circumstance should be indicated by the use of modifier 54. A value of 70 percent of the listed reimbursement value is allowed for this circumstance.
 - B. Postoperative Management Only:** If a medical provider provides the postoperative care only, the use of modifier 55 is warranted. A value of 20 percent of the listed reimbursement value is appropriate.
 - C. Preoperative Management Only:** If a medical provider provides the preoperative care only, the use of modifier 56 is warranted. A value of 10 percent of the listed reimbursement value is appropriate.
- XII. Two Surgeons:** When two surgeons work together as primary surgeons performing a distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including any add-on procedure(s)) is performed during the same surgical session, a separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of the additional procedure(s) during the same surgical session, those services may be reported using the separate procedure code(s) with modifier 80 or modifier 82 added as appropriate. Modifier 62 is used primarily when two surgeons with different skills are required in the management of a specific surgical problem (e.g., a urologist and a general surgeon in the creation of an ideal conduit).
- XIII. Procedure Performed on Infants Less than 4 kg:** Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and medical provider work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. This modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology or Laboratory, or Medicine sections. Use of modifier 63 should result in an increased payment for the surgical

procedure.

- XIV. Surgical Team:** Under some circumstances, highly complex procedures (requiring the services of several medical providers, often of different specialties, plus other highly skilled, specially trained personnel, and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating medical provider with the addition of modifier 66 to the basic procedure number used for reporting services.
- XV. Surgical Assistants:** When an assistant at surgery service is required, use the following numeric codes: surgical procedures for which an assistant at surgery may be allowed with supporting documentation (0), assistant at surgery never allowed (1); assistant at surgery allowed (2), and assistant at surgery concept does not apply (9). Appendix A of The Essential RBRVS lists the CPT code and the numeric assistant at surgery designation. Modifiers for assistant at surgery services are as follows:
- A. Assistant Surgeon:** Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).
 - B. Minimum Assistant Surgeon:** Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number. This modifier may also be used to identify assistant surgeon services provided by Physician Assistants, Nurse Practitioners and Advanced Practice Nurses where assistant surgeon services are appropriate.
 - C. Assistant Surgeon (when a qualified resident surgeon is not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).
 - D. Concurrent Care:** When separate procedures or services are provided by two or more medical providers on the same date, each medical provider should indicate his or her service(s) by appropriate procedure code(s). This circumstance does not warrant any increase or reduction in value. This circumstance can only be used if the procedures performed do not qualify for the use of modifiers 62 or 66. Consultations are an exception.
- XVI. Multiple Procedures (Same Surgeon):** Procedures performed on the same date which significantly increases time and skill warrants the use of modifier 51. Modifier 51 should be added to the secondary, tertiary, etc. procedure code(s). Multiple procedures should be listed by the value according to the fee schedule in descending order. The primary procedure should reflect the greatest value and should not be reported with modifier 51. All other procedures should be listed in decreasing value according to the fee schedule with modifier 51 appended. The appropriate payment for each procedure is as follows: for the primary procedure, 100 percent of allowed fee; for second, third, fourth and fifth procedures, 50 percent of the allowed fee; for sixth and subsequent procedures, By Report.
- XVII. Bilateral Procedures:** Some procedures, which are performed on both left and right (bilateral procedures), warrant the use of modifier 50 for the second procedure. Follow appropriate rules of valuation listed under Multiple Procedures.
- XVIII. Materials Supplied By Medical provider:** CPT code 99070 or the specific HCPCS Level 11 code may be used to identify materials provided by the medical provider (e.g., dressings, casting supplies, drugs, etc.) over and above those usually indicated with the office visit. For those codes (such as 99070) that do not have an allowed fee, however, refer to section 24.29.1521 in the Administrative Rules of Montana (ARM).

Section Four: Radiology

- I. General:** If a relative value is not available for a radiology code, it is indicated with a "0.00" in the total units columns. When no total relative value unit has been established the value should be substantiated by report (BR). Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service or supply. For example, the technical components of radiology codes do not have a medical provider work component, so the work component is indicated with "0.00."
- Listed values for radiology procedures apply only when these services are performed by or under the supervision of a medical provider.
- II. Modifiers:** Modifiers identify circumstances that alter or enhance the description of the service. For radiology codes, two modifiers affect the assigned unit value and are listed in The Essential RBRVS. Other modifiers, however, may be required for correct reporting of the service. See CPT 2007 and HCPCS Level II publications for additional information on modifiers. Listed radiology modifiers in The Essential RBRVS affect the unit value as follows:

- A. **Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical value of providing that service. The following sections, professional and technical, provide additional definitions for each component.
- B. **Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring medical providers.
- C. **Technical:** Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service.
- III. **Supervision and Interpretation Only:** A code designated as "supervision and interpretation only" is used to indicate the radiological component of a service that has both a radiological and procedural component (e.g., injection, insertion of catheter, etc.). These two-component services may be performed by a single medical provider or two medical providers, usually a radiologist and another medical provider (e.g., surgeon, cardiologist, urologist, etc.). When a single medical provider performs both components of the service, current CPT guidelines require the medical provider to report both the radiological supervision and interpretation component (70000 series code) and the procedural component (surgical or medicine code). When two medical providers perform the procedure, each medical provider reports only the component provided either the radiological supervision and interpretation component or the procedural component.
- IV. **Unlisted Services or Procedure:** A service or procedure that is not identified by a particular code should be listed under the appropriate "Unlisted Procedure." Usually, these procedures have "9" as the final digit. Values should be substantiated by report. See By Report.
- V. **Unusual Procedural Services:** When a procedure of unusual nature is performed, modifier 22 should be added and value substantiated by report. See By Report.
- VI. **By Report:** The value of a procedure should be established for any by report circumstance by identifying a similar service and justifying value difference. Procedures that require a report should include the following:
- Accurate definition
 - Clinical history
 - Related procedure values
 - Reason for value adjustment
- VII. **Portable X-Ray:** Use HCPCS code Q0092 to indicate set-up of a portable x-ray.
- VIII. **Separate or Multiple Procedures:** Multiple procedures performed on the same date should be listed separately. Payment is set at 100% of the fee schedule allowed amount.
- IX. **Reduced Services:** If a medical provider elects to reduce the value of a procedure, modifier 52 should be added to the procedure code. For example, modifier 52 and the appropriate code may be used to indicate a limited or follow-up CT scan.
- X. **Services or Procedures Listed in Other Sections:** Services or procedures provided by a radiologist may be listed in another section of the CPT book (e.g., consultations listed in Evaluation and Management). The radiologist should use the procedure codes following the guidelines appropriate to that section.
- XI. **Modifiers:** A listing of CPT modifiers is provided in the Introduction.

Section Five: Pathology and Laboratory

- I. **General:** If a relative value is not available for a code, it is indicated with a "0.00" in the total unit columns. When no total relative value unit has been established the value should be substantiated by report (BR). Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service. For example, many codes in the Pathology and Laboratory section have only nonfacility and facility practice expense components listed because these services do not contain medical provider work or malpractice cost components. The total nonfacility and total facility units for those services having only a practice expense component will be the same as the listed practice expense component.

Values in this section include recording of the specimen, performance of the test, and reporting of the result. They

do not include specimen collection, transfer, or individual patient administrative services.

II. Modifiers:

- A. **Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical cost of providing that service.
- B. **Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated; performance and/or supervision of the procedure or lab test; interpretation and/or written report concerning the examination or lab test; and consultation with referring medical providers.

III. Unlisted Service or Procedure: A service or procedure that is not identified by a particular code should be listed under the appropriate unlisted procedure code. These procedures generally have "9" as the final digit. Values should be substantiated by report. See By Report.

IV. Unusual Procedural Services: When a procedure of unusual nature is performed, modifier 22 should be added and value substantiated by report. See By Report.

V. By Report: The value of a procedure should be established for any "by report" circumstance by identifying a similar service and justifying the difference. Procedures that require a report should include the following:

- Accurate definition
- Clinical history
- Related procedure values
- Reason for value adjustment

VI. Reference (Outside) Laboratory: The laboratory tests and services listed in this section, when performed by other than the medical provider; require the applicable procedure number with the appropriate modifier (90). See the Introduction for a complete modifier description.

VII. Repeat Clinical Diagnostic Laboratory Test: Tests repeated the same day for the same patient to obtain multiple results require use of modifier 91. See Introduction for complete modifier description.

VIII. Collection and Handling: Collection and handling of laboratory and pathology specimens may be reported separately. To report handling of specimens, see codes 99000 and 99001 in the Medicine section. Collection is reported using codes from the Surgery section. For routine venipuncture, see 36415. For venipuncture over age three years, requiring medical provider skill, see 36410. For venipuncture by cutdown, see 36420-36425. For collection of capillary blood specimen, see 36416. For collection of specimen from implanted venous access device, see 36540. For routine arterial puncture, see 36600. For arterial catheterization, see 36620-36625. Use CPT code 36415 for reporting of venipuncture.

IX. Multiple Procedures: Multiple procedures performed on the same date should be listed using modifier 51. Payment is set at 100% of the fee schedule allowed amount.

X. Reduced Services: If a medical provider elects to reduce the value of a procedure, modifier 52 should be added to the procedure code.

XI. Consultation: Several codes are listed for various types of pathology consultations. (See 80500-80502, 88321-88334). Medicine codes may also be used, if appropriate.

XII. Services or Procedures Listed in Other Sections: Services or procedures provided by a pathologist may be listed in an alternate section of the CPT book (e.g., consultations listed in Medicine). The pathologist should use these procedure codes following the guidelines appropriate to that section.

XIII. Modifiers: A comprehensive listing of modifiers is provided in the Introduction.

Section Six: Medicine

I. General: If a relative value is not available for a Medicine code, it is indicated with a "0.00" in the total units columns. When no total relative value unit has been established, the value should be substantiated by report (BR). Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service or supply.

Listed values for Medicine procedures apply when these services are performed by or under the supervision of a medical provider.

- II. Modifiers:** Modifiers identify circumstances that alter or enhance the description of the service. For Medicine codes two modifiers affect the assigned unit value and are listed in The Essential RBRVS. Other modifiers may be required for correct reporting of the service. Listed Medicine modifiers in The Essential RBRVS affect the unit value as follows:
- A. Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical value of providing that service. The following sections, professional and technical, provide additional definitions for each component.
 - B. Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring medical providers.
 - C. Technical:** Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service.
- III. Separate Procedures:** Procedures identified as "separate procedures" are frequently included in the global value of other procedures. Listing of a separate procedure code and full value is appropriate if the procedure is not included in the global value of another. Listing of separate procedure codes is not appropriate when the procedure is included in the global value of another.
- IV. Unusual Procedural Services:** A service may necessitate skills and time of the medical provider over and above listed services and values. If substantiated by report (BR), additional values may be warranted. Use modifier 22 to indicate these procedures.
- V. Unlisted Service or Procedure:** When a service or procedure provided is not adequately identified, use of the unlisted procedure code for the related anatomical area is appropriate. Most codes of this type have "9" for the last digit. The value should be substantiated by report (BR).
- VI. By Report:** The value of a procedure should be established for any "by report" circumstance by identifying a similar service and justifying value difference. When a report is required, the report should include the following:
- Accurate procedure definition or description
 - Justification for procedural variance, when appropriate
 - Similar procedure and value
 - Justification for value difference
- VII. Reduced Services:** Under some circumstances, the value for a procedure may be reduced. Use modifier 52 to identify reduced value services.
- VIII. Multiple Modifiers:** If circumstances require the use of more than one modifier with any one procedure code, modifier 99 should be added to the procedure code. Other modifiers are then attached to the procedure code and listed separately with appropriate values for each.
- IX. Materials Supplied By Medical Provider:** CPT code 99070 or the specific HCPCS Level II code may be used to identify materials provided by the medical provider (e.g., sterile trays, drugs) over and above those usually indicated with the office visit. For codes (such as 99070) without a listed value in RBRVS, please refer to rule 24.29.1521 of the Administrative Rules of Montana (ARM).

Section Seven: Evaluation and Management

- I. General:** If a relative value is not available for a procedure, it is indicated with a "0.00" in the total unit columns. When no total relative value unit has been established, the value should be substantiated by report (BR).
- II. Glossary:** Visits, examinations, consultations, and similar services listed in this section reflect wide variations required in time and skill. The following alphabetical listing of definitions is included to aid in the determination of the correct code for the service provided. Documentation for each aspect of the service performed should be included in the patient record to substantiate the level of service. Listed values for each code group apply only when these services are performed by, or under the supervision of, a medical provider.

Chief Complaint. A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter.

Classification of Service. Each code in this section is grouped into a category. The groupings are defined by place (e.g., office, hospital, nursing home, etc.) and type of service (e.g., consultation, preventive, etc.). Some of the codes are grouped into subcategories (e.g., new patient, established patient, initial, etc.). Each code in the group represents a different level of service defined by the clinical components of a patient encounter for E/M. See Levels of Service.

Components. Each level of service recognizes seven components. The components include history, physical examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time. See Levels of Service, Key Components, History, Physical Examination, Medical Decision Making, Counseling, Problem, and Time.

Concurrent Care. The provision of similar services (e.g., hospital visits) to the same patient by more than one medical provider on the same day.

Consultation. There are two categories for consultation: outpatient and inpatient. Any medical provider may use an appropriate consultation code on any patient for any problem including one which has been previously evaluated by the consulting medical provider provided the following criteria are met:

- The attending medical provider or appropriate source requests that the medical provider render advice or opinion regarding the evaluation and/or management of a specific problem
- The need for the consultation, the consultant's opinion, and any services ordered or performed must be well documented in the patient's record
- The information is communicated to the requesting medical provider or appropriate source

If the consulting medical provider upon completion of the consultation assumes care of the patient, the services subsequent to the consultation are reported with the appropriate office/outpatient, inpatient, or other E/M service codes.

When a consultation is initiated by the patient or family without a request by a medical provider or other appropriate source, the service is not reported with consultation codes. The service is instead reported using the appropriate office visit, home service or domiciliary/rest home care codes.

Counseling. A discussion with the patient and/or family concerning one or more of the following:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management options
- Instructions for management and/or follow-up
- Importance of compliance with chosen management
- Risk factor reduction
- Patient and family education

See Key Components and Time.

Established Patient. A patient who has received professional services from a medical provider or another medical provider in the same specialty within the same group within the last three years. In the instance a medical provider is covering for or on call for another medical provider, the patient is classified as an established patient if the other medical provider or a member of the providing medical provider specialty group has provided services for the patient within the last three years.

Family History. A review of medical events in the patient's family that includes significant information about:

- Health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in Chief Complaint, History of the Present Illness, and/or System Review
- Diseases of family members that may be hereditary or place the patient at risk

History. This key component relates to the type of history obtained during a patient encounter. The four types of history are defined as follows:

- Problem focused: brief history of present illness or problem as related to the chief complaint
- Expanded problem focused: brief history of present illness relating to chief complaint and pertinent system review
- Detailed: extended history of present illness related to chief complaint, an extended system review, and pertinent past, family and/or social history
- Comprehensive: extended history of present illness related to chief complaint, complete system review and complete past, family and social history

History of Present Illness. A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, associated signs, and symptoms significantly related to the presenting problem(s).

Key Components. Those components that are used primarily to determine the appropriate code level. These components are history, medical decision making, and physical examination. Time is not considered a key component unless counseling constitutes more than 50 percent of the face-to-face patient/medical provider encounter. See also History, Medical Decision Making, Physical Examination, Time, and Counseling.

Levels of Service. Each category and subcategory contains three to five levels of service indicated by code. The services include examinations, evaluations, treatments, conferences with or concerning patients, preventative pediatric and adult health supervision, and similar services. Each level of service recognizes seven clinical components. Three of these components are considered key components, including history, medical decision making, and physical examination. All medical providers may use each level of service.

Medical Decision Making. The complexity of establishing a diagnosis or selecting a management option. Medical decision making is divided into four categories. The level of medical decision making is determined using documentation in the patient record for three subcategories including: number of possible diagnoses and or the number of management options considered; the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options. The following four classifications for level of medical decision making are used in determining the proper code:

- Straightforward: minimal number of possible diagnoses or management options, minimal or no amount and/or complexity of data to be reviewed, and minimal risk of complications and/or morbidity or mortality
- Low Complexity: limited number of possible diagnoses or management options, limited amount and/or complexity of data to be reviewed, and low risk of complications and/or morbidity or mortality
- Moderate Complexity: multiple number of possible diagnoses or management options, moderate amount and/or complexity of data to be reviewed, and moderate risk of complications and/or morbidity or mortality
- High Complexity: extensive number of possible diagnoses or management options, extensive amount and/or complexity of data to be reviewed, and high risk of complications and/or morbidity or mortality.

Nature of Presenting Problem. A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal: a problem that may not require the presence of the medical provider, but service is provided under the medical provider's supervision
- Self-limited or minor: a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance
- Low severity: a problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected
- Moderate severity: a problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment
- High severity: a problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment

New Patient. A patient who has not received any professional services from a medical provider or another medical provider in the same specialty within the same group within the past three years. In the instance where a medical provider is on call for or covering for another medical provider, the patient is classified as a new patient if the other medical provider is a member of the providing medical providers specialty group has not provided any

professional service for the patient within three years. See also Established Patient.

Past History. A review of the patient's past experiences with illnesses, injuries, and treatments that include significant information about:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies (e.g., drug, food)
- Age appropriate immunization status
- Age appropriate feeding/dietary status

Physical Examination. This key component relates to the type of physical examination performed during a patient encounter. The four defined types of physical examination are:

- Problem focused: an examination limited to the affected body area or organ system
- Expanded problem focused: an examination of the affected body area or organ system and other symptomatic or related organ systems
- Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s)
- Comprehensive: a complete single system specialty examination or a complete multi-system examination

Problem. Describes the nature of the issue presented as the reason for the encounter. The problem is considered to be a contributing factor and therefore is not used as a primary factor in determining level of service. The problem includes the same five categories as Nature of Presenting Problem.

Review of Systems. An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms, which the patient may be experiencing or has experienced. For the purposes of these CPT definitions, the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/immunologic

Social History. An age appropriate review of past and current activities that includes significant information about:

- Marital status and/or living arrangements
- Current employment
- Occupational history
- Use of drugs, alcohol, and tobacco
- Level of education
- Sexual history
- Other relevant social factors

Time. Time for an outpatient is considered to be face-to-face time spent with the patient and does not include time spent in such activities as record review or dictation. The time for an inpatient is considered to be the time spent "on the floor" and does include record review, dictation, and other services rendered while in the facility unit of the patient. Times given are considered to be an average and should not be used to determine the length of time spent in the encounter. Time is considered to be a contributory factor and as such is not used to define the level of service unless 50 percent or more of the service performed is spent in counseling or coordinating care. In cases

where 50 percent of the service is counseling or coordinating care, time is used as the primary component for defining the level of service. Careful documentation of time is essential in cases where time is the defining component.

- III. Unusual Procedural Services:** A service may necessitate skills and time of the medical provider over and above listed services and values. If substantiated by report (BR), additional values may be warranted. Use modifier 22 to indicate these procedures.
- IV. Unlisted Service or Procedure:** When a service or procedure provided is not adequately identified, use of the unlisted procedure code for the related anatomical area is appropriate. Most codes of this type have "9" for the last digit. Services should be substantiated by report (BR). See By Report.
- V. Prolonged Evaluation and Management Service:** When a service provided is prolonged or otherwise greater than that usually required for the E/M service, use of modifier 21 or prolonged service codes is appropriate. Time must be documented.
- VI. Unrelated E/M Service by the Same Medical provider During a Post-operative Period:** If a service which is not related to the original procedure and is performed during the follow-up period for that period, the service may be identified by modifier 24 to indicate this service is unrelated.
- VII. Significant, Separately Identifiable E/M Service by the Same Medical provider on the Same Day of a Procedure or Other Service:** When an E/M service is performed on the same day of a procedure, separate reporting of the E/M service may be allowed. The E/M service must be for a condition that required services above and beyond the normal pre- and postoperative care associated with the procedure. Use modifier 25 to indicate this type of service.
- VIII. E/M Service Resulting in Initial Decision for Surgery:** If an evaluation and management encounter results in the initial decision to perform surgery, modifier 57 may be attached to the E/M service code.
- IX. By Report:** The value of a procedure should be established for any "by report" circumstance by identifying a similar service and justifying value difference. When a report is indicated, the report should include the following:
 - Accurate procedure definition or description
 - Operative report
 - Justification for procedural variance, when appropriate
 - Similar procedure and value
 - Justification for value difference
- X. Reduced Services:** Under some circumstances, the value for a procedure may be reduced. Use modifier 52 to identify reduced value services.
- XI. Multiple Modifiers:** If circumstances require the use of more than one modifier with any one procedure code, modifier 99 should be added to the procedure code. Other modifiers are then attached to the procedure code and listed separately with appropriate values for each.
- XII. Materials Supplied by Medical provider:** CPT code 99070 or the specific HCPCS Level II code may be used to identify materials provided by the medical provider (e.g., dressings, casting supplies, drugs, etc.) over and above those usually indicated with the office visit. For codes (such as 99070) without a listed value in the RBRVS, see section 24.29.1521 of the Administrative Rules of Montana (ARM).

Section Eight: HCPCS

- I. General:** If a relative value is not available for a HCPCS code, it is indicated with a "0.00" in the total units columns. Individual units columns may also have a "0.00" when one or more of the components do not apply to the listed service or supply. For example, many codes in the HCPCS section have only nonfacility and facility practice expense components listed because supplies do not contain work or malpractice cost components. The total nonfacility and total facility units for those supplies and services having only a practice expense component will be the same as the listed practice expense component.

Since HCPCS Level I codes (CPT) do not contain all the codes needed to report medical services and supplies HCPCS Level II codes were developed. Level II codes begin with a single letter (A through V, though not all the letters are used) followed by four numeric digits. They are grouped by the type of service or supply they represent and are updated annually. Check an official 2007 HCPCS Level II publication for the groupings as well as additional reporting guidelines related to the use of these codes.

- II. Modifiers:** Modifiers identify circumstances that alter or enhance the description of the service or supply. Some modifiers appear in the HCPCS section of The Essential RBRVS. However, other modifiers may be required for correct

reporting of the service. See CPT 2007 or an official 2007 HCPCS Level II publications for additional information on modifiers. Modifiers in the HCPCS section are as follows:

- A. **Total:** When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of the professional services and technical value of providing that service. The following sections, professional and technical, provide additional definitions for each component.
- B. **Professional:** Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring medical providers.
- C. **Technical:** Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service
- D. **Started but Discontinued Procedure:** Modifier 53 indicates a started but discontinued procedure. See the modifier section in the Introduction for more information about modifier 53.
- E. **HCPCS Level II Modifiers:** HCPCS Level II modifiers differ from Level I (CPT), and are more specific and limited in their application. Three Level II modifiers are used in the HCPCS section. Reporting of HCPCS services and supplies may require the use of additional modifiers. In addition to the discussion of modifiers in our Introduction, see an official 2007 HCPCS Level II publication for a complete list of modifiers. The Level II modifiers included in this section are:
 - NU New Equipment
 - RR Rental Equipment
 - UE Used Durable Medical Equipment (DME)

III. Gap Values: Valuation of CPT Level I and HCPCS Level II Codes: Wherever possible, the Montana WC Nonfacility Fee Schedule relies on the Ingenix The Essential RBRVS publication for CPT and HCPCS Gap code RVU values. For codes (such as 99070) that do not have a unit value, see section 24.29.1521 of the Administrative Rules of Montana (ARM).

IV. Valuation of Drugs and Biologicals: See our separate Administrative Rules of Montana section (24.29.....) for prescription drug reimbursement information

V. Gap Values for Relative Values less than 0.01: Some CPT Level I and HCPCS Level II codes are valued with a relative value less than 0.01. The relative value for these codes has been rounded up to 0.01 in order to distinguish them from codes with no established value.